SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

> Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).

> Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at 1-800-538-5038 (TTY Users: 711)

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at 1-844-208-9012 (TTY Users: 711) or the Compliance Hotline at 1-800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 1-800-537-7697).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: 1-800-538-5038.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: 1-800-538-5038。

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: 1-800-538-5038。

Language Access Services


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Language Access Services


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Individual Plans Utah Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS.

Note: For plans purchased through the Federally Facilitated Marketplace (FFM), all requested changes and terminations MUST be processed through the FFM. Visit healthcare.gov or call 800-318-2596.

A. SUBSCRIBER INFORMATION

Subscriber’s Name __________________________ Subscriber ID# __________________ Date of Birth __________________

(LOCATED ON ID CARD)

B. SUBSCRIBER INFORMATION CHANGES

Name Changed from __________________________ Marital Status Change □ Legally Married □ Divorced □ Deceased

Name Changed to __________________________ Effective Date of Marital Status Change __________________

New Physical Address __________________________ __________________________

New Mailing Address __________________________ __________________________

City __________________________ State ______ ZIP ______ New Ph# (____ ) ______

C. ADD NEW ELIGIBLE DEPENDENTS

NEWBORNs, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED WITHIN 60 DAYS (WHEN THERE’S A CHANGE IN PREMIUM) OF GAINING THE DEPENDENT, OR 31 DAYS (WHEN THERE’S NO CHANGE TO PREMIUM) FROM WHEN THE FIRST CLAIM IS RECEIVED.

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>SEX M/F</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH MM/DD/YY</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>TOBACCO USER?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ spouse □ natural child □ adopted</td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
</tbody>
</table>

D. TERMINATE DEPENDENTS

CHILDREN (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>TERMINATION DATE MM/DD/YY</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ coverage through other parent (divorce) □ government coverage (e.g., medicare, medicaid, etc.) □ individual coverage □ other</td>
</tr>
</tbody>
</table>

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>TERMINATION DATE MM/DD/YY</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ annulment □ death □ divorce □ coverage on parent’s plan □ employer group coverage □ government coverage (e.g., medicare, medicaid) □ other</td>
</tr>
</tbody>
</table>

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth.

Spouse’s Signature __________________________ Date __________________________

E. CANCEL COVERAGE

□ I hereby request to stop receiving medical benefits received under Contract by SelectHealth®. I understand that this stoppage will be effective on the last day of the month following receipt and approval of this request by SelectHealth. Furthermore, I understand that no cancellation will be made on a retroactive basis.

If you would like a termination date other than the end of the month, write it in the space below.

Date __________________________

□ I wish to stop receiving my medical benefits because I am leaving for active military service.

F. SIGNATURE

By signing, you agree to the changes requested above and acknowledge that your monthly premium may change. To terminate coverage, please mark a box in section “E” above before signing.

Subscriber Signature __________________________ Date __________________________
USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

For plans purchased through the FFM, all requested changes and terminations MUST be processed through the FFM. Visit healthcare.gov or call 800-318-2596.

SECTION A. SUBSCRIBER INFORMATION
Complete this section using the policyholder’s full name and Subscriber ID. You can find this number on your ID card. If you purchased your plan through the FFM, certain changes may be made through the FFM. For more information, contact your SelectHealth-appointed agent or call Individual Sales at 855-442-0220.

SECTION B. SUBSCRIBER INFORMATION CHANGES
This section is only required for name, marital status, address, or phone number changes.

SECTION C. ADD ELIGIBLE DEPENDENT CHILDREN
Use this section only to add eligible dependents as outlined in your Contract. If you are adding a dependent outside of open enrollment, proof of a qualified life event will be required. Life events that may qualify you for a Special Enrollment Period (SEP) include getting married, having a baby, moving to a new residence, adopting a child, and more. For more information, call Individual Sales at 855-442-0220.

SECTION D. TERMINATE DEPENDENTS
Use this section to remove your spouse or dependent children. Authorized removal of dependents may be done at any time during the year as long as SelectHealth is notified in advance. For more information, call Individual Sales at 855-442-0220.

SECTION E. CANCEL COVERAGE
Complete this section if you wish to terminate your policy.

SECTION F. SIGNATURE
Only the subscriber’s signature is acceptable. Unsigned change forms cannot be processed and will cause a delay in fulfilling your request.

Submit the completed change form to:
SelectHealth
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: 801-442-5798
Email: individualenrollment@selecthealth.org

When emailing sensitive information, please use your My Health account on selecthealth.org.